DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES	/19	<u>_</u> -t-	1103/14	FOF	ED: 11/21/2013 RM APPROVED	
CENTERS FOR MEDICARE &		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		445071	B. WING			11/17/2013		
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	1711/2013	
CLAIBOI	RNE COUNTY NURSI	NG HOME		ı	50 OLD KNOXVILLE ROAD ZEWELL, TN 37879			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETION DATE		
K 029 \$S=D	One hour fire rated fire-rated doors) or a extinguishing system and/or 19.3.5.4 prot the approved autom option is used, the a other spaces by smidoors. Doors are sefield-applied protections.	construction (with ¾ hour an approved automatic fire in accordance with 8,4,1 ects hazardous areas. When latic fire extinguishing system treas are separated from oke resisting partitions and elf-closing and non-rated or ive plates that do not exceed bottom of the door are	K	029	Corrective Action Taken: 1.(a) Fire stop caulking was applied to seal the identified penetration above the ceiling room 111 on11/20/13. (b) Fire stop caulking was applied around the identified floor laundry dryer to seal to identified penetration on 11/20/13.	g in S		
	This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined hazardous area's fire rated construction is maintained and combustible storage rooms larger than 50 square feet were provided with door closers. The findings include: 1. Observation and interview with the Maintenance Director, on November 17, 2013 at 12:00 p.m. confirmed unsealed penetrations in the following areas: a) Above ceiling by room 111, b) 1st floor laundry dryer vents that penetrated the rated wall were not sealed. c) 2nd floor above structural member above the lay-in ceiling by room 216. 2. Observation and interview with the Maintenance Director, on November 17, 2013 at 11:15 a.m. confirmed the first and 2nd floor shower rooms were used to store combustibles were not provided with door closers (NFPA 101,				(c) Fire stop caulking was applied to seal the identified penetration on 2 nd floor abo structural member above to lay-in ceiling by room 216 of 11/20/13. 2. Door closures were install the identified 2 nd floor show room doors on 11/25/2013. How to identify similar issue building inspection was conducted by the Maintenar Department personnel to identy other fire and/or smoke penetrations in the nursing. The inspection tour also incall storage areas of combus materials to ensure that door	l ve he on lled to ver A nce entify wall home. cluded tible		
	19.3.2.1 (7). DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	<u>i</u>	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is/determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U5R121

Facility ID: TN1301

If continuation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
445071			B. WING			11/17/2013	
NAME OF PROVIDER OR SUPPLIER CLAIBORNE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETION DATE
K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing syster and/or 19.3.5.4 prot the approved autom option is used, the a other spaces by smidoors. Doors are sefield-applied protecti	construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When atic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or the plates that do not exceed bottom of the door are	K	029	closures were installed and in use. Responsible Person: Facility/Safety Manager Measures put in place: (1) Building inspection tours have been increased from annually biannually. These inspections will be conducted by the Maintenance Department personnel. Smoke and fire wa penetrations will be checked fat this time. The personnel	to 11	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined hazardous area 's fire rated construction is maintained and combustible storage rooms larger than 50 square feet were provided with door closers. The findings include: 1. Observation and interview with the Maintenance Director, on November 17, 2013 at 12:00 p.m. confirmed unsealed penetrations in the following areas: a) Above celling by room 111, b) 1st floor laundry dryer vents that penetrated the rated wall were not sealed. c) 2nd floor above structural member above the lay-in ceiling by room 216. 2. Observation and interview with the Maintenance Director, on November 17, 2013 at 11:15 a.m. confirmed the first and 2nd floor shower rooms were used to store combustibles were not provided with door closers (NFPA 101,				inspecting will make sure a we order for repair is submitted used to completion of rounds for each penetration found. (2) Regula monthly Preventive Maintenar rounds will include inspection functioning door closures in required areas. Monitoring: (1) Building inspection documentation will submitted to the Facility/Safet Manager biannually upon completion. The # of complet work orders for repair of fire/smoke wall penetrations completed within 48 hours / I total # of work orders for fire/smoke wall penetrations =	r nce for be y	
		VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	<u>!</u>	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseble 14 days following the date these documents are made available to the facility. If deficiencles are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445071 11/17/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD CLAIBORNE COUNTY NURSING HOME TAZEWELL, TN 37879 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 of compliance. Compliance rate SS≃D is expected to be 100%. The One hour fire rated construction (with % hour Facility/Safety Manager will fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 report the rate of compliance to and/or 19.3.5.4 protects hazardous areas. When the Environment of Care the approved automatic fire extinguishing system Committee and the Quality option is used, the areas are separated from Management Committee other spaces by smoke resisting partitions and biannually at the first scheduled doors. Doors are self-closing and non-rated or meeting after receipt of the field-applied protective plates that do not exceed 48 inches from the bottom of the door are written inspection report. (2) permitted. 19.3.2.1 Monthly inspection of presence of functioning door closures in required areas reports will be submitted to the Facility/Safety This STANDARD is not met as evidenced by: Manager monthly. # of Based on observation and interview, it was functioning door closures in determined hazardous area 's fire rated required areas / Total # of construction is maintained and combustible required areas requiring door storage rooms larger than 50 square feet were provided with door closers. closures = % of compliance. The findings include: Compliance rate is expected to 1. Observation and interview with the be 100%. The Facility/Safety Maintenance Director, on November 17, 2013 at Manager will report rate of 12:00 p.m. confirmed unsealed penetrations in the following areas: compliance to Environment of a) Above ceiling by room 111. Care Committee and Quality b) 1st floor laundry dryer vents that penetrated Management Committee at each the rated wall were not sealed. scheduled meeting until 100% c) 2nd floor above structural member above the compliance is sustained for 3 lay-in ceiling by room 216. consecutive months. 2. Observation and interview with the Responsible Person: Maintenance Director, on November 17, 2013 at

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Brown

11:15 a.m. confirmed the first and 2nd floor

shower rooms were used to store combustibles

were not provided with door closers (NFPA 101,

Administrator

Facility/Safety Manager

COMPLETION DATE:

12/15/2013

(X6) DATE

12/15/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

19.3.2.1 (7).

Event ID: U5R121

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING			OMB NO. 0938-0391 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:				CO	COMPLETED	
NAME OF	445071					11	/17/2013	
NAME OF PROVIDER OR SUPPLIER CLAIBORNE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFE TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETIO DATE	
K 147 SS=D	Continued From page 1 These findings were verified by the Maintenance Supervisor and acknowledged by the Risk Manager during the exit conference on November 17, 2013. NFPA 101 LIFE SAFETY CODE STANDARD		K 02	CODE STANDARD Corrective Action Taken:		ne n		
	Electrical wiring and with NFPA 70, Nati	trical wiring and equipment is in accordance NFPA 70, National Electrical Code, 9.1.2			removed 11/17/13. All equipment in use was plugged into the existing wall outlets.			
	Based on observat determined extension adapters were not use The findings include Observation and introduced power statement on November 118 were being used This finding was ver	on not met as evidenced by: ion and interview, it was on cords and multiple outlet ised for medical devices. e: erview with the Maintenance ber 17, 2013 at 2:00 p.m. rips in rooms 102, 108, and d with oxygen concentrators. ified by the Maintenance howledged by the Risk			How to identify similar issue. All resident rooms were chees by the nursing staff for other power strips in use. Each postrip found was removed immediately and equipment plugged into existing outlet plugs.	cked wer was		
	Manager during the exit conference on November 17, 2013				Measures put in place: (1) Usuadmission to the Nursing Holeach caregiver involved in the process will be made aware no power strips are to be brown into the facility. This instruction is to be added to the admission checklist. Responsible Person Social Worker. (2) The nurse staff will observe resident roon each 2 hour rounds for	ome, nis that ought tion on m:		
					presence of power strips and remove them if found, (3)			

NAME OF PROVIDER OR SUPPLIER

17, 2013.

CLAIBORNE COUNTY NURSING HOME

Continued From page 1

The findings include:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X4) ID PREFIX

TAG

K 029

SS=D

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

These findings were verified by the Maintenance

Manager during the exit conference on November

Electrical wiring and equipment is in accordance

with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:

determined extension cords and multiple outlet

Observation and interview with the Maintenance

Based on observation and interview, it was

adapters were not used for medical devices.

Director, on November 17, 2013 at 2:00 p.m.

This finding was verified by the Maintenance Supervisor and acknowledged by the Risk Manager during the exit conference on November

confirmed power strips in rooms 102, 108, and

118 were being used with oxygen concentrators.

Supervisor and acknowledged by the Risk

K 147 NFPA 101 LIFE SAFETY CODE STANDARD

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

445071

PRINTED: 11/21/2013 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 11/17/2013 STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 149 K 029 to be educated by the Director of Nursing on safety aspect of why power strips are not allowed and what to do if they are found in use. Attendance will be verified K 147 by employee signature on attendance sheet. (4) During regular monthly preventive maintenance on Resident rooms, maintenance employees are to observe for unapproved power strips in use and remove them. Maintenance employees are to be educated on this by the Facility/Safety Manager. Attendance will be verified their signatures on the attendance sheet.

Monitoring: Random "rounds" will be made by the Charge Nurse weekly to check for power strips in use. Charge nurse rounds will be assigned by the Director of Nurses /Designee. Completed round findings will be submitted to the Director of Nurses who will then calculate the rate of compliance. The rate of compliance will be determined by: the number of rooms with no power strips in use / The total #

FORM CMS-2567(02-99) Previous Versions Obsolete

17, 2013

Event ID: U5R121

Facility ID: TN1301

If continuation sheet Page 2 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/21/2013 FÖRM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445071 B. WING 11/17/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1850 OLD KNOXVILLE ROAD CLAIBORNE COUNTY NURSING HOME TAZEWELL, TN 37879 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 147 K 029 Continued From page 1 K 029 of rooms surveyed = the rate of These findings were verified by the Maintenance compliance. Expected Supervisor and acknowledged by the Risk compliance rate is 100%. This Manager during the exit conference on November data will be presented to the 17, 2013. K 147 NFPA 101 LIFE SAFETY CODE STANDARD Administrator monthly and to K 147 SS≃D Quality Management Committee Electrical wiring and equipment is in accordance bimonthly by the Director of with NFPA 70, National Electrical Code. 9.1.2 Nurses. Responsible Person: Director of Nurses COMPLETION DATE: 12/15/13 This STANDARD is not met as evidenced by: 12/15/2013 Based on observation and interview, it was determined extension cords and multiple outlet adapters were not used for medical devices. The findings include: Observation and interview with the Maintenance Director, on November 17, 2013 at 2:00 p.m. confirmed power strips in rooms 102, 108, and 118 were being used with oxygen concentrators. This finding was verified by the Maintenance Supervisor and acknowledged by the Risk Manager during the exit conference on November 17, 2013